Managed Care in Children's Mental Health

Chapter 2

Lessons Learned From The Fort Bragg Demonstration

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Introduction

The Fort Bragg demonstration provided a comprehensive approach to the delivery of mental health and substance abuse services to a population of approximately 48,000 (FY95) military-related children under 18 years of age who resided within the Fort Bragg catchment area. A major purpose of the project was to study the implications of expanding the health care benefit package provided to military families through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) by providing a full continuum of mental health and substance abuse services (Bickman et al., 1995).

As an experiment in systems change, the Fort Bragg demonstration yields a wealth of valuable "lessons learned" for policymakers, practitioners, researchers, and consumers. These lessons have implications both for those involved in children's systems reform efforts, as well as those undertaking managed care initiatives affecting children and their families.

Method

Over the last six months of the demonstration, over two hundred individuals were interviewed, including administrators, clinicians, families, policymakers, and other stakeholders, who had been involved in the Fort Bragg project since its inception. Interviews were conducted by a team of independent policymakers, researchers, family members, and clinicians, all of whom have been

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involved in national and state systems reform issues over the last decade. The team also reviewed the extensive written documentation available from the demonstration, the formal evaluation conducted by Vanderbilt University, and client characteristic and service data over the life of the project.

What Fort Bragg Was and Was Not

Through the study, there emerged greater clarity as to what the Fort Bragg demonstration was and was not.

Fort Bragg *was not* managed care. The demonstration sought specifically to increase access and utilization without particular regard to cost, in contrast to managed care, which is concerned fundamentally with controlling cost by managing access and utilization. There was no risk attached to management and service contracts (which were cost-reimbursable); many incentives existed, on both the supply and demand side, to provide and use services.

The demonstration also *was not* a system of care; that is, it was not an integrated continuum of mental health and related services and supports in which there is shared "ownership" of the system across multiple child-serving systems (i.e., education, child welfare, juvenile justice and mental health).

Fort Bragg *was not* a continuum for "high end users" (i.e., children with serious disorders, only). Nearly 60% of the evaluation sample received no service more intensive than outpatient.

Fort Bragg *was* a demonstration of a community-based continuum of mental health and substance abuse services, with a single point of access, for a total child/adolescent eligible population (i.e., for both acute and extended care populations and for children with both mild and serious disorders). It changed an existing, poorly regarded system, as it intended; it expanded the array of services, eliminated co-pays and deductibles, reduced use of inpatient and residential treatment, increased access and utilization, and was held in generally high regard by families and the larger community. With this success, however, there emerged countervailing pressures and issues (e.g., cost pressures, overutilization of multiple services, unrealistic expectations on the part of some families and clinicians, and apparent cost shifting to and from the demonstration). To its

credit, the demonstration made every effort to be a self-correcting experiment.

Critical Lessons Learned

Service Utilization

At least two important lessons emerge from looking at the greatly expanded service utilization created by the demonstration. The first is the "if you build it, they will come" lesson. If mental health services are offered to families in ways that are accessible, stigma-reducing, and individualized, they will be used–and probably more heavily than a developing system can accommodate without creating problems in other areas, such as cost problems, inadequate provider training, inadequate monitoring, and quality assurance. A response to these problems is not necessarily to restrict access, which remains a worthwhile policy goal, but rather to design the demonstration and manage services during implementation in ways that promote more deliberative start-up and efficient treatment.

A second lesson from looking at service utilization in Fort Bragg is the importance of analyzing as accurately as possible the population eligible for services prior to implementation (i.e., who and how many can be expected to use services). This requires striking some balance between using prior utilization and prevalence data. The Fort Bragg demonstration was hampered by the inadequacy of the Army's data regarding how many children were using services and the types of services being used, as well as the insistence to base expected use on prior utilization only. There is a particular lesson here for managed care initiatives which have a tendency to rely on prior utilization to develop capitation rates. The Fort Bragg project suggests strongly that use of prior utilization alone will be an inaccurate predictor if it is applied to a more attractive, accessible, community-based continuum of behavioral health services.

Fort Bragg points to the need for individualized *system* planning for different subclusters of children in a total eligible population. For example, while "high end" users may need intensive case management and treatment planning, this is clearly not the case for children using only outpatient services. Children involved in other public systems, particularly child welfare, will require more time on the part of clinicians to manage the boundaries between the systems and deal with the requirements of the other system. Children with ADHD may require less intensive involvement with mental health but greater collaboration with the pediatric services. Fort Bragg suggests an important lesson about the need to desegregate the eligible population into types of users and institute approaches that make sense for different subpopulations–the "not every child needs the same system" lesson.

Cost

Perhaps the most important cost-related lesson from Fort Bragg is that of linking cost and quality issues in design and implementation–a lesson which Fort Bragg itself learned, somewhat painfully, and took steps to change. It is not possible to maintain quality of care without paying attention to cost; clinical viability alone is not sufficient. Inevitably, costs will run high if not attended to from the outset, leading to enormous pressures for cost containment that then can jeopardize quality of care. Cost containment pressures, in turn, will aggravate tendencies of cost-shifting to other child-serving systems.

A related cost lesson is the importance of thinking through in advance the effect on supply and demand of the incentives that are built into the system for providers and consumers to provide and use services, respectively. To its credit, Fort Bragg took a number of steps by the latter half of the demonstration (post the evaluation phase) to

modulate some of these incentives and control costs without necessarily jeopardizing quality of care. It also instituted greater efficiencies in service delivery through the following: (a) streamlining its intake process; (b) emphasizing shorter-term, problem solving therapies; (c) adhering more closely to level of care criteria; (d) instituting guidelines for use of psychiatrists; (e) streamlining its case management process; and (f) streamlining the treatment planning process. It created more structured utilization review, with a clearer focus on length of stay, and imposed a more integrated focus on cost, quality, and service issues through its quality improvement process with feedback loops to service providers about both cost and quality. In this process, the demonstration also had to begin to clarify its own values about cost and quality issues–again, an important lesson. When cost containment values were introduced into the service system late in the demonstration, there was indeed a dramatic reduction in the cost of providing treatment.

A strong argument can be made from the Fort Bragg experience that research and development costs and costs associated with requirements imposed by demonstration sponsors should be budgeted and tracked separately from the costs associated with service delivery. Fort Bragg also suggests (as do many other demonstrations in the children's arena) that the time normally accorded to systems change efforts (typically, three to five years) is simply too short to preclude inefficiencies in start-up, development, and modification of new approaches (Friedman, 1996).

A final cost lesson from Fort Bragg relates to the possibility that greater efficiencies may very well have been achieved, at least with respect to Fort Bragg children involved in multiple systems, had the demonstration actually implemented a system of care with shared ownership across the major child-serving systems, instead of a continuum of mental health services "owned" by the Army. Certain inefficiencies occurred because separate systems prevailed.

Service Delivery

A great many lessons can be drawn from the demonstration about effective service delivery.

Regarding *intake and assessment:*

- Intake staff need access to an array of crisis options;
- intermediate-level services, particularly in-home services, need to be available from the outset to prevent inappropriate hospitalization and residential care;
- an intake process that focuses on presenting problems, using a problem list, rather than on "nailing a diagnosis" is needed to promote efficiency;
- small co-pays are needed to prevent an initial recurring problem of missed appointments; and
- intake staff need to be trained well in the treatment philosophy and goals of the demonstration, how the service system is organized, and the resources available to them.

Regarding the treatment team process:

- It is critical to make the treatment team responsible for managing/monitoring length of stay and appropriateness of care to better link treatment and cost concerns;
- a multidisciplinary treatment team does not have to be held for every child entering the system but should be reserved for children with serious or complex disorders;

- the more people who are involved in the treatment team process, the more time-consuming and expensive it will be (i.e, multiple players on the treatment team may aggravate the problem of overuse of multiple services, since each player has a tendency to become an advocate for the service he or she is representing, which also drives up costs);
- an effective treatment team process is one governed by tight clinical leadership and a better understanding of how the various levels of care relate to one another;
- much more needs to be learned about what service components work best for which types of children over what period of time; and
- it is important to be creative in treatment planning and not allow a child to stay in an inappropriate level of care simply because the needed service is unavailable.

Quality Improvement

A number of lessons can be drawn about quality improvement (QI). The QI program should be developed with the involvement of staff and providers, as well as families, and incorporate peer review to create ownership and "buy-in." QI should provide information to clinicians concurrently with service provision, not retrospectively, so that feedback in areas such as length of stay and family satisfaction gets to providers in a timely fashion, not after the fact. QI should track more than cost and utilization; it needs also to track systems outcomes across the continuum, client outcomes, and family and youth satisfaction. QI and utilization review functions need to be integrated. QI data needs to be tied to credentialling of providers. It is unrealistic to expect a full-blown QI program to be in place before clinical services are fully developed. Implementation of an effective QI program is a developmental process that requires time.

Staff and Provider Network

One of the lessons of Fort Bragg is the importance of orienting the staff and provider network to the values and goals of the demonstration and of evaluating staff and providers against the demonstration's desired outcomes. Because differing values are inevitable among staff and providers, it is essential to articulate clearly the demonstration's values as a unifying element and to create an in-house process to air and resolve differing values. Without such a process, staff become polarized around different philosophies, instead of working synergistically.

Family Involvement

Perhaps the most salient lesson about family involvement is the danger in assuming that everyone means the same thing by "family involvement," the importance of articulating clearly what the demonstration means by it and the importance of training staff in the demonstration's philosophy and service approach to families. There needs to be clinical leadership to help families make good decisions. Lack of strong clinical leadership, particularly at a systems level, affects cost. In the absence of such leadership, there is a tendency for staff and providers to overload families with services and for families to become dependent, aggravating lengths of stay and therefore cost.

Environmental Context

Systems change experiments in the children's arena operate in complex political, social, and interagency environments. Particularly in the children's arena, changes in one system will affect all other child-serving systems.

Fort Bragg reinforces the usefulness of environmental and ethnographic analysis for anticipating how services will be used and for informing deliberations about optimal treatment approaches for the target population. For example, it might be anticipated that ready access would be a major factor in the willingness of Army families to use services because of the Army mentality of "do it now." Similarly, the location of services off-base might also have been anticipated to increase demand for services because of the preference of military families to use non-base providers, particularly for mental health services where stigma is an issue. The transiency of the military family, particularly those at this rapid deployment base, might have argued in the design phase for shorter-term, problem-solving treatment approaches and shorter lengths of stay. The rapid deployment nature of the base, which has the effect of depleting medical staff from the base, might also have been anticipated to result in some patient-shifting from the Army medical center on-base to the demonstration, as indeed occurred.

Evaluation

Just as it is essential for demonstration implementers to be clear about their purpose, it is critical that evaluators are careful to define clearly what it is they are evaluating. It also is critical that appropriate caveats be included regarding comparison sites that are used. Typically, there are political, operational, and other constraints that influence the choice of comparison sites, which necessarily affects comparability. Those involved in the demonstration believe that the most, perhaps only, comparable site to Fort Bragg is Fort Hood, which, for a number of reasons, could not be used (L. Behar, personal communication, Summer, 1995). Both bases, unlike the comparison sites that were used, are involved in rapid deployment, house specialized forces, have large pediatric populations, have high birth rates, and have a large concentration of low income military personnel. It is possible that these factors create more difficult-to-treat mental health problems. If this is the case, then the fact that Fort Bragg had outcomes as good as, and in some cases, better than the comparison sites that were used, is encouraging. Similarly, a caveat might have been noted regarding the potential influence on outcomes of co-pays and deductibles, with which families at the comparison sites, but not Fort Bragg families, had to contend. Families at the comparison sites may have been more motivated, due to the presence of co-pays and deductibles, to use services and to use them more efficiently. This motivation, in turn, may have helped to produce better treatment outcomes.

In assessing adequacy of implementation, evaluators need to be clear about the stage of implementation that is being evaluated, as systems change experiments are highly developmental in nature. They also need to define carefully what aspects of implementation are being assessed and the limitations of those aspects to creating a holistic picture of implementation. The Fort Bragg evaluation, for example, evaluated case management and intermediate services as indicators of adequacy of implementation. The evaluation did not assess the appropriateness of case management for the various populations of children receiving that service, which proved to be an issue. The evaluators assessed intermediate services in one clump, rather than separately, making it impossible to determine whether certain components were more or less well developed than others, which might affect results. Also, at the time of the implementation evaluation, the demonstration was at a relatively early stage of development, besieged by a heavy demand for services, an influx of new providers, and without well developed internal management and control, quality assurance and utilization review mechanisms, all of which affected results.

Evaluators need to be very careful in their interpretation of cost findings. In Fort Bragg, one might have concluded that the high costs associated with the demonstration were exactly what might have been anticipated given its design. This is a quite different interpretation than saying that costs were higher than expected. This goes back to the earlier point about the importance of both the demonstration and the evaluation being clear about purpose and goals.

Summary

Demonstrations are expected to undertake many new endeavors very quickly. Fort Bragg, for example, had to simultaneously educate the community, hire new staff, contract with outside providers, start new programs, build internal management and monitoring mechanisms, respond to sponsor demands for information and adjustments, orient and train new staff and providers, find facilities, etc. Multi-faceted systems, changing experiments in the children's arena, need time and a deliberately phased timetable, with benchmarks along the way, to be implemented (and evaluated) effectively.

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Symposium: Public-Sector Managed Care for Children's Mental Health Services: Stakeholders' Perspectives

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Introduction

Beginning in January 1994, North Carolina implemented a program that blended capitated financing with public-sector managed care for mental health and substance abuse services. The program is called Carolina Alternatives (CA), and it covers children eligible for Medicaid. This symposium is designed to outline the structure of CA and present stakeholders' perspectives on the first two years of implementation. The stakeholders to be represented include (a) the State's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) and its local branches (Area Programs); (b) the state, private, and general hospitals that provide mental health and substance abuse services to children; (c) the county Social Service Departments (DSS); and (d) both the children who receive services and their parents. Initial cost findings on both inpatient and outpatient service delivery will also be presented.

Stakeholders' Perspectives: Overview of Carolina Alternatives

Dan Tweed, Ph.D.

During the late l980's, the Health Care Finance Administration (HCFA) was concerned that Medicaid funds were being used to hospitalize children who might be better treated in other settings. Medicaid regulations require three criteria before a hospital admission

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qualifies for Medicaid reimbursement: (a) the child has a mental health condition warranting care under the supervision of a physician; (b) the child can benefit from hospitalization; and (c) more appropriate services are not available in the child's community.

In North Carolina, HCFA's concerns led to the implementation of a Utilization Review (UR) program in August of 1990. The program was designed by North Carolina's Division of Medical Assistance (DMA) and implemented by a private-sector managed care company operating under contract with DMA. Designed to ensure that Medicaid regulations were being observed, the UR program incorporated two of the fundamental tools of a managed care system–a pre-certification review process designed to divert children from hospitalization when more appropriate forms of care were present, and a continued stay review process designed to ensure that children were not hospitalized longer than clinically necessary.

Only a subset of North Carolina's hospitals were initially targeted by the UR program, but this subset accounted for over 90% of Medicaid-reimbursed inpatient stays. Analyses suggested that the UR program appeared to be effective. Pre-post comparisons suggest significant reductions in the number of inpatient days provided, reductions in inpatient expenditures, and substantial savings for both North Carolina and the Federal Government.

Effective as it was, however, the program had obvious limitations. First, the program was designed as a simple UR strategy. Even though the program's mission included determining if more appropriate community-based services were present, it had no care management component. If a child was denied admission, there was no process in place to ensure that the child received an appropriate alternative service. Second, if the program was working as designed, the potential for further reductions in inpatient utilization was limited by the lack of community-based alternatives in the child's community of origin. Availability of community-based alternatives, in turn, was limited by the lack of funding to build good systems of care. What was needed was a managed care strategy capable of generating savings and converting those savings into alternative community-based services. Under the UR program, savings stayed in state and federal coffers.

Carolina Alternatives

Beginning in April of 1991, North Carolina's Division of MH/DD/SAS collaborated with DMA to design a new program, Carolina Alternatives (CA), which could overcome the weakness of the UR program. During the first two years, CA was implemented in 10 of North Carolina's 41 Area Programs. This pilot period served to road test CA and set parameters needed for statewide implementation. Under CA, several things happened. First, the local Area Programs became responsible for the management of all medicaid-reimbursed services delivered to children in their service areas. This included responsibility for the utilization review process *and* responsibility for finding appropriate care when inpatient care was deemed inappropriate.

Second, in order to carry out the managed-care role, pilot programs were given a prospectively determined budget with which to provide or purchase appropriate forms of care. Pilot programs were expected to live within this budget and were at full risk for expenditures in excess of the budgeted amount. For the first two years of implementation, however, the pilot programs received a prospectively determined budget having two distinct components, one expressly designated for the purchase of inpatient services and the other for the purchase of outpatient services (including the full range of non-inpatient forms of care). Area programs were at full risk for the inpatient component only. Any savings accrued from diverting children to less costly community-based alternatives was kept by the Area Programs.

By contrast, the pilot programs enjoyed a two year "moratorium" on risk for outpatient expenditures. Pilot programs were reimbursed for excess outpatient expenditures, while unspent money was returned to the state. Outpatient expenditures during the moratorium period were used to determine the full capitation rate that went into effect at the end of the moratorium period. Thus, CA created a strong incentive to both divert children from inpatient services and spend money on the outpatient side. The intent behind this incentive structure was to provide a stimulus for the development of new community-based services.

Carolina Alternatives' design stimulated the development of community-based services along three lines. First, savings from reductions in the number of inpatient days purchased were used as flexible dollars to buy services which might otherwise not be covered under NC's mental health benefits structure. Alternative forms of residential treatment were included here. Second, the two year moratorium on outpatient risk created an incentive to shift the costs of caring for the needs of children with serious problems to the outpatient side, leading Area Programs to either invest in the development of new in-house capacity or to incorporate an expanding base of private contract providers. Finally, the program provided an incentive for hospitals to offer outpatient alternatives to inpatient care. Faced with fewer admissions, fewer days, and fewer dollars, hospitals were induced to enter the outpatient services market in a more aggressive manner.

With these thoughts in mind we now review how the program has been working. We approach this question in two ways. First, we share the views of several key stakeholder groups whose views can fundamentally condition the success of a program like CA: (a) the pilot programs implementing CA in quite varied circumstances; (b) the inpatient providers whose activities have been profoundly affected by CA; (c) the DSS agencies who often see the same clients, compete for the same residential capacity and often seek mental-health care for their clients; (d) the patients and their families; and (e) the state Mental health office. Second, we review expenditure patterns on inpatient and outpatient services to determine the presence of program effects on expenditures.

Stakeholders' Perspectives: Area Programs, Hospitals and Departments of Social Services

Dalene Stangl, Ph.D.

Introduction

This section presents the perspective of three groups regarding how CA restructured service delivery, implemented care management, and redefined interagency relations. Problems encountered by each group are also presented. The three groups are (a) the 10 Area Programs responsible for care management, (b) the hospitals that provide mental health and substance abuse services to children, and (c) the DSS directors for each county. Each of these groups has an important stake in the delivery of mental health and substance abuse services to children, and hence, each group provides an essential perspective to understanding the inner-workings of this public-sector managed care program.

Methods

In July 1994, six months after initial implementation of CA, mail-out questionnaires designed by two authors (DT and DS) were sent to all 41 Area Programs. These questionnaires tapped general attitudes toward managed care and familiarity with CA. In addition, the 10 participating Area Programs were sent a second questionnaire that asked about initial management experiences. These latter questionnaires helped prepare the researchers for subsequent interviews. Personnel from participating Area Programs (i.e., CA coordinators, utilization review managers, management information system personnel and finance personnel) were interviewed face-to-face, on-site, at two time points. The first interview was conducted by two of the authors (DS and DT), during August/September, 1994. These interviews assessed the managed care strategy and service structure of each Area Program. The second interview occurred during February, 1996, 26 months into the program, and was conducted by one of the authors (DS). It was preceded by a single mail-out questionnaire to all 41 Area Programs that asked updated but parallel questions to the previous questionnaires.

Thirty-five hospital administrators responsible for negotiating service contracts with the Area Programs were interviewed over the telephone at two points in time. The first interview was in July/August, 1994, and the second interview was during July/August, 1995. The first of these interviews was conducted by the author (DS) and the second by a research assistant trained by the author (DS).

Finally 100 DSS directors were interviewed over the telephone during July, 1995. These interviews were conducted by a research assistant. Copies of interviews and/or questionnaires may be obtained from the author (DS).

Results

Area Programs

Modeling the structure of CA as a wheel, Medicaid and the State Office of MH/DD/SAS are the hub and the Area Programs are the spokes. The Area Programs carry the weight of the program in that they are responsible for implementation and are at-risk for excess expenditures above and beyond the capitation amount. They have expended a great deal of time, thought, energy, and patience in designing, implementing, and adapting to an evolving process. Most results presented here will be from the 26-month interviews conducted and questionnaires collected in February of 1996.

Service Delivery: All 10 Area Programs reported that CA resulted in decreases in the average length of time until children received first treatment. Estimates ranged from decreases of 1 to 30 days, with 5 days

representing the median decrease. Of the 10 Area Programs, 9 reported increases in in-house direct care staff and/or treatment slots, in residential treatment slots, and in case management staff. All 10 Area Programs developed and maintained an extensive network of private contract providers. The number of contracts with individual care providers ranged from 10 to 78 (median = 32), and with group providers, ranged from 10 to 33 (median = 12).

Admission rates to hospitals from the 10 Area Programs decreased, and the average length of hospital stays were reduced to less than 30 days, with 9 of 10 Area Programs reporting average lengths-of-stay less than 14 days. Formal grievances from the hospitals were minimal with most Area Programs experiencing no grievances that were unresolved at the local level.

Care Management: Area Programs were asked to report how extensive efforts to manage inpatient care were during the first two years of the program. On a scale of 1 to 7, (1 = *Not at all Intense,* 4 = *Moderately Intense,* and 7 = *Extremely Intense*), eight Area Programs rated their efforts as 5 or higher, with 4 rating their efforts as extremely intense. The 2 remaining Area Programs rated their efforts at level 3. On the outpatient side, Area Programs anticipate that efforts to manage outpatient care will have to be equally intensive with the onset of outpatient capitation.

After two full years of implementation, only 3 of the 10 Area Programs felt they were still at moderate risk of deficit spending for inpatient care. The remaining 7 reported very little or no risk of deficit spending for inpatient care. The opposite was true for deficit spending on the outpatient side. Here 7 Area Programs reported being at moderate to substantial risk of deficit spending. The other 3 programs reported little to some risk of deficit spending.

The most common barriers to managing inpatient care reported by the Area Programs was the lack of community-based alternative services. This barrier was reported by 8 of 10 Area Programs. Other barriers reported by at least 3 Area Programs were lack of experience with the managed care process and lack of clarity from the state.

The two most commonly reported barriers to managing outpatient care were poor communication with service providers and fluctuating expectations as the Area Programs move from outpatient growth to containment. Until January, 1996, Area Programs were provided full reimbursement for outpatient services. Now outpatient services are also reimbursed on a capitated basis. Hence, the first two years of CA resulted in outpatient service expansion, while January, 1996 marked the beginning of service containment. Area Programs reported nervousness about their abilities to maintain service provision at the same levels as the first two years of the program. Other barriers reported by at least 3 Area Programs included lack of sufficient community-based services, conflicting philosophies with service providers, and lack of clarity from the state.

Interagency Relations: As gatekeepers to service delivery and payments, Area Programs are the principle decision makers, and this may present a source of conflict for other agencies. Competent communication and negotiation skills are crucial. Questions pertaining to Area Programs' relationships with Department of Social Service, Juvenile Justice, and Education showed that while most relationships have some problems and some fluctuated frequently, 40% of the relationships remained the same, and 50% improved since the beginning of CA.

Other Results: Nine of 10 Area Programs described dissatisfaction with their management information systems in at least one of the following areas: claims management, patient tracking, utilization review, and patient scheduling. All Area Programs attained savings from inpatient capitation

reimbursements during the first two years of CA. Area Programs estimated that 22 to 58% of that savings was spent on administrating the program.

The final question asked of Area Programs was: "If CA ended today, how would you evaluate what it has done for children's mental health in your area?" The responses resonated a common chorus. Area Programs reported that CA has developed greater continuity of care for children by the improving quality and quantity of services and requiring accountability for the entire spectrum of care. Access to services has improved, with more children being served in each Area Program. Mental health centers are working pro-actively with communities to develop a wide spectrum of services. Communication has improved so that now information is passed with the child across episodes and providers. Accountability has increased, both in terms of fiscal responsibility as well as service provision. CA has provided better coordination and communication between all stakeholders in the process.

Hospitals

Hospitals are an important stakeholder in CA. As service delivery is restructured and less costly outpatient services substituted for inpatient ones, hospitals stand to lose the most. Because only about 30% of children eligible for Medicaid reside in the vicinity of participating Area Programs, the full impact of CA on hospitals has yet to be seen, but change is evident. As of July, 1995, 74% of the 35 hospitals serving children with mental health and substance abuse problems had signed a CA contract with at least one Area Program. The results provided below are from the July, 1995 interviews with administrators from these hospitals.

Service Delivery: Fourteen percent of hospitals reported plans to decrease inpatient capacity, and 80% of those planning a decrease, attribute their action to CA. Forty percent report plans to increase their outpatient capacity, and of those planning an increase, 43% attribute the change to CA.

Care Management: As of July, 1995, hospitals had signed a total of 61 contracts with the 10 Area Programs. Each hospital rated each Area Program with whom they had a contract on several dimensions of care management. Hospitals were asked whether Area Programs exercised *too little, about right,* or *too much* control on the hospitalization process. Sixty percent of the ratings fell in the *about right* category, and 27% fell in the *too much* category, down from 44% in 1994.

Hospitals also rated Area Programs on their ability to manage inpatient care. Seventy-five percent of the ratings fell in categories ranging from *satisfactory* to *very well.* When asked to compare the utilization review of the Area Programs to that of the private company providing the review prior to CA, 35% reported that the Area Programs were more responsive to the needs of children; 22% reported the Area Program and private company were about equally responsive; 22% reported Area programs were asked about responsiveness, and 22% did not know. Similar percentages were reported when the same question was asked with respect to the needs of the hospital rather than needs of the children.

Other results: Finally hospitals were asked to rate the impact of CA on the children they served. Forty-three percent reported that CA had a *favorable* or *extremely favorable* impact; 26% reported *negligible,* and 23% reported *unfavorable.*

Departments of Social Service

In most Area Programs, the transition of DSS into CA has not been smooth. Notions of medical necessity and treatment versus placement have been slowly accepted by DSS departments. Area Programs worry that the advances made with DSS departments during the growth in the uncapped outpatient

services period will be lost as more stringent efforts at managing outpatient services are necessary under the second phase of CA. Results presented here are from telephone interviews conducted in July, 1995.

Service Delivery: DSS directors were asked the following question: As a consequence of CA, do you think that the mental health service options available to children eligible for Medicaid (1) *Improved very much,* (2) *Improved,* (3) *Remained the same,* (4) *Deteriorated,* (5) *Deteriorated very much or* (6) *Don't know?* Ten percent of the DSS departments in CA participating counties reported some level of deterioration, while 53% reported some level of improvement. The remaining 36% fell in the *remained the same* or *don't know* categories.

Care Management: DSS directors were asked the following question: Under CA, your local mental health agency serves as the single entry point for children needing mental health services; given your experience with the local mental health agency, how effective do you think they have been in this role? Of CA participating counties, 68% responded that Area Programs had been moderately or very effective in their role. Of the nonparticipating counties, who will eventually participate, 85% expect the Area Programs will be moderately or very effective in their managed care role.

Interagency Relations: Directors were asked to describe problems they encountered in their relationship with the Area Programs. The most frequent problem mentioned by DSS was too slow or infrequent contact between agencies. This was true regardless of whether or not the county was currently participating in CA. Of the participating counties (n = 31), 23% reported this problem, while 36% of nonparticipating counties (n = 69) reported this problem. No other problem was reported by more than 10% of the participating counties. Among the nonparticipating counties, more than 10% reported problems with Area Programs in the areas of untrained staff, understaffing, misunderstood DSS functions, and inability to serve children with special needs. These percentages ranged from 12% to 17% of the nonparticipating counties.

Conclusions

CA has had its share of hurdles. These hurdles are reflected in the three perspectives presented here. The coming years will be no different, and tensions are likely to be exacerbated by capitated reimbursement for outpatient services and by implementation in the remaining 31 Area Programs. Area Programs will have a tough managed-care role as they tighten control on outpatient services. Interagency relations will continue to have ups and downs. Hospitals will continue to lose demand for inpatient services and need to substitute outpatient services. Area programs, DSS departments, and mental health and substance abuse service providers must continue to be flexible and creative as they are forced to adapt the service system to new financing approaches. Hopefully in the mission to improve both efficiency and effectiveness of treatment, CA will continue to increase access and delivery of a broad spectrum of community-based services.

Stakeholders' Perspectives: Client Satisfaction and Outcomes

Elizabeth M.Z. Farmer, Ph.D. & Julia S. Gagliardi

Children and families who use the public mental-health system are the most important stakeholders in CA. They are the ones for whom CA was created and the ones with the most to gain or lose depending on the success of the program. A set of measures was developed and pilot tested to explore both client satisfaction and to assess child outcomes.

Method

A team of individuals–composed of representatives from the state Division of MH/DD/SAS, Area Programs, Family advocacy groups (Families Can and AMI), and Duke University–developed the measures. The group focused their efforts on developing measures that met several core requirements. The measures must assess satisfaction and outcomes (process measures were already under discussion elsewhere), should be simple to both administer and interpret, had to tap "real world" dimensions, and should be useful to a variety of stakeholders (e.g., the local Area Mental Health Programs, the State, legislative committees). The committee recognized that the initial measures would be the first step in an ongoing process of development.

The child outcome measures included assessment of problems and functioning in six domains (i.e., (a) school/work/vocational training; (b) family/residential; (c) peer relations; (d) behavior; (e) substance use; and (f) involvement with the legal system). It also included a checklist of treatment foci and the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, Bickman, & Kurtz, 1991).

The satisfaction measures were designed to gather information at key points in a child's treatment process (i.e., at first contact with the center, at initial treatment planning, and at annual update of the treatment plan or planned termination of treatment). Each of these forms focused on issues that were of particular relevance at the given stage of treatment. In addition, a measure was designed to assess the satisfaction of families who dropped out of treatment.

Pilot data on the satisfaction measures were collected in nine Area Programs that were participating in CA. Data collection continued for one month and included all children and parents/guardians who met the criteria for the questionnaires (e.g., all clients who had a first contact, clients who had annual updates of treatment plans). Questionnaires were given to both a parent/guardian who accompanied the child and to the child (for children who were at least ten years old).

Questionnaires were completed while the family was still in the clinic and were returned in an envelope or to a "drop box" to insure confidentiality. Satisfaction of clients who dropped out of service were collected via telephone interviews with the parent/guardian.

Results

A total of 275 forms were included in the analysis. Of these, 115 were "first contact" forms, 68 reported on satisfaction at "initial treatment planning," 53 reflected views at annual review or planned termination, and 39 were completed by parents/guardians of children who had recently dropped out of treatment. Available data suggests a completion rate of approximately 79%, though this rate varied considerably across programs.

The following results highlight areas of particular satisfaction, as well as areas that showed room for improvement. At first contact, 99% of respondents expressed adequate satisfaction with their experience (i.e., 75% were *very satisfied* and 24%

were *somewhat satisfied*). Eighty-one percent reported that they were seen at the Area Program within two weeks of first calling to make an appointment, and 91% felt that this response time was satisfactory. Sixty-eight percent reported that they experienced no barriers or difficulties in obtaining services. Of those who did report difficulties, the most commonly reported problems were lack of transportation, lack of information, and concerns about costs. Other questionnaires continued to show an overall high level of satisfaction with services. Areas of particularly high satisfaction included communication (e.g., "staff members listened to what you said," "staff understood the needs of your child and family"), and efficacy of treatment (e.g., "treatment helped you deal more effectively with problems"). Areas that showed a need for improvement included parental participation in treatment planning and removing barriers to care to prevent families from dropping out of treatment.

Pilot testing of the outcome measure included 28 clinicians or case managers who completed the assessment on 41 active cases. Results indicated that the forms were acceptable to staff members, covered domains that they considered to be important, and could be completed in less than ten minutes.

The involvement of representatives from a variety of perspectives and organizations in the development of the satisfaction and outcome measures increased interest in the measures and willingness to implement them. Pilot testing showed that the satisfaction and outcome measures were acceptable to clients and staff members, could be completed quickly with reasonable return rates, and gathered information that was of interest and use to the intended stakeholders.

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Stakeholders' Perspectives: Preliminary Cost Findings

David Langmeyer, Ph.D.

This portion of the symposium presents a comparison of service costs between Area Programs that participated in CA and those that did not. Comparisons within each group across time are also presented.

Method

During the first two years of CA, the 10 participating Area Programs were paid a capitated rate for inpatient services and a fee-for-service rate for non-inpatient services, while the 31 non-participating Area Programs were paid a fee-for-service rate for both inpatient and non-inpatient services. Hence, all costs presented here were calculated based on fee-for-service rates. For this report, costs represent the Medicaid rate paid for services. It is the cost to Medicaid payers (Federal, State and County) on a fee-for-service basis.

Information about the costs under CA was gathered from the North Carolina Medicaid paid claims files for all Area Programs in 1992 and the non-participating Area Programs in 1994. For participating Area Programs, 1994 and 1995 information came from reimbursement reports of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

It is known that there is under reporting on the paid claims files. Not all services, particularly non-inpatient services, are reported. This underestimates the cost of non-inpatient services for both non-participating and participating programs in 1992, as well as for non-participating programs in 1994. The result is that cost increases for participating programs is exaggerated.

Results

From 1992 (before capitation) to 1994 (first year of capitation), total value of services for participating Area Programs went up by 72% (see Table 1). Non-participating Area Programs operating under fee-for-service increased total value of service by under 4%.

Some of the increase was due to an increased number of eligible children under 18. For CA participating Area Programs, there was a 26% increase in eligible months between 1992 and 1994. For non-participating Area Programs, this increase was 22%. Combining total value of service and number of eligibles, the cost per eligible month increased for participating Area Programs from 1992 to 1994 and decreased for non-participating Area Programs in the same period of time. Participating Area Programs increased cost per eligible month by 36% and non-participating Area Programs decreased cost per eligible month by 5%.

In general, CA was very successful in reducing costs associated with inpatient services. From 1992 to 1994, the cost per person served in inpatient settings dropped by 45% from $14,976 per person to $8,249. Non-participating Area Programs started at about the same level as participating Area Programs in 1992 and increased slightly in 1994 (+2%).

Offsetting the decrease in inpatient service was a dramatic increase in non-inpatient service for participating Area Programs. Value per person served in non-inpatient settings rose from $785 to $2,552, a 225% increase. There was also a sharp increase in non-participating Area Programs' value per person served from $603 to $1,466 (+143%).

The decrease in inpatient services and increase in non-inpatient services about balanced out. The total value per person served for participating Area Programs in 1992 was $3,203. This went up very slightly in 1994 ($3,280). The non-participating

Table 1
Cost Comparison of Participating Area Programs versus Non-participating Area Programs

	1992	1994
Total Value of Service		
Participating	$16,465,977	$28,320,659
Non-participating	$30,831,338	$31,995,702
Eligible Months		
Participating	$1,071,694	$1,350,289
Non-participating	$2,847,897	$3,477,604
Total Cost Per Eligible Month		
Participating	$15.36	$20.97
Non-participating	$10.82	$ 9.20
Inpatient		
Participating	$14,976	$ 8,249
Non-participating	$14,878	$15,157
Per Person Served, Non-Inpatient		
Participating	$785	$2,552
Non-participating	$603	$1,466
% Eligibles Receiving Services		
Participating	7.5%	
Non-participating	4.8%	
Total Value Per Person Served		
Participating	$3,203	$3,280
Non-participating	$3,072	N/A

Area Programs were comparable (-4.3%) in 1992 (1994 was not available at time of the report).

Aside from increasing the amount of service provided, another feature of CA was to increase availability of services. Evidence supporting this accomplishment is provided by the fact that in 1994, participating Area Programs served 7.5% of eligible children compared to non-participating Area Programs serving 4.8% of eligible children.

The reduction in inpatient services was expected, and in fact, was the basis of undertaking CA in the first place, but the dramatic increase in non-inpatient services needs to be explored. One aspect of the increase is in the mix of services which were provided. In 1994, over 60% of the non-inpatient service dollars went for "High Risk Intervention." This service barely existed (as a billable service) in the 1992 paid claims files. A new service accounted for the increase in total value of non-inpatient services. Non-participating Area Programs seem to be following the same pattern as CA programs in the growth of non-inpatient services, but with a lag of a few months. The month-to-month paid claims for non-inpatient events in non-participating Area Programs grew rapidly from July 1994 until March 1995 (1.5 million to 3 million). It is likely that the differences in non-inpatient billing between participating and non-participating Area Programs will decrease when 1995 and 1996 information becomes available.

Managing Care Through Limited Risk, Bundled Contracting

Introduction

Managed care is becoming the major mechanism for the allocation and management of services and resources, not only for private health care, but throughout populations traditionally served by public service systems. This technology has moved into mental health services and is becoming the future of all child and family serving systems, including child welfare (Valentine, Fisher, Feild, Webman, & Web, 1995). This has led many communities to experiment with the key principles of managed care before converting to managed care in a formal sense. The summary describes a method of managing resources that builds on these principles in order to allocate a pool of blended, flexible dollars in Ohio's largest metropolitan county.

History

Franklin County has a rich heritage of intersystem and public/private collaboration. Individualized planning and creative funding have been important facets of the service system for high risk children and youth through *Kids In Different Systems* (KIDS), the local Child and Family First Intersystem Council, since 1992. The Council is comprised of the local child and family serving systems along with provider and parent representation (see Figure 1).

Through a pilot project called the *10 Kids Project*, KIDS experimented with bundled contracting through a panel of private, non-profit mental health service providers. In this project, ten

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youths in out-of-county placements were brought back to their community through individualized planning and collaborative implementation (Cauble, et al., 1992). This project successfully demonstrated the effectiveness of collaborative planning when supported by flexible funding for serving high risk, high use youth with multiple needs. It also demonstrated better outcomes and cost efficiency by serving them in, or near their own homes. A second project demonstrated similar results with a group of multi-need children with mental retardation served by one, for-profit agency. In this project, the concept of limited risk contracting was formalized.

Objectives of Flexible Funding

Since late 1991, Franklin County has been committed to the flexible allocation of blended dollars to support individualized plans that are strength based and family centered. The following values were fundamental in the development of this process:

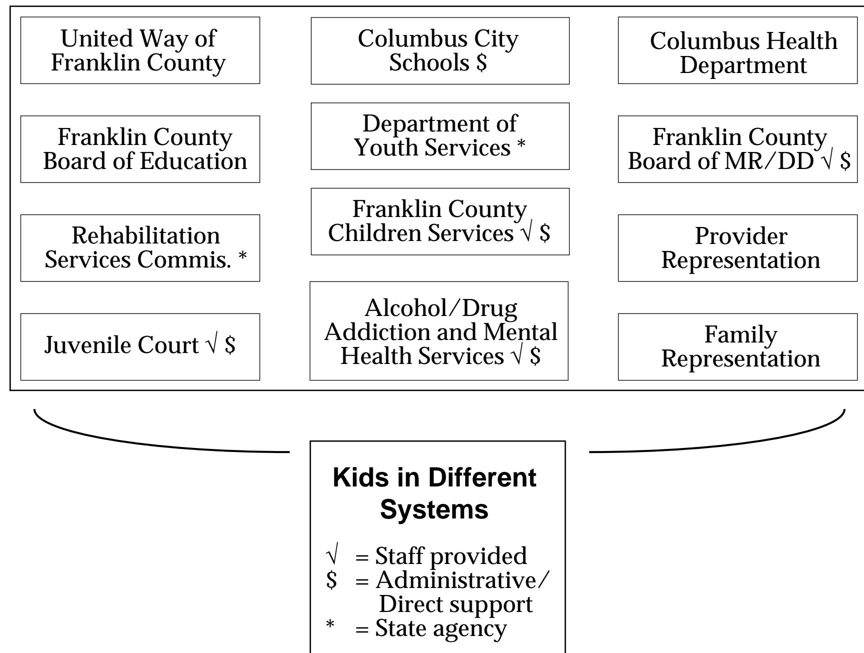
- Locus of decision making at the family team level (family centered).
- Optimum flexibility.
- Community flexibility.
- Accountability/tractability.
- Outcome oriented.
- Sensitivity to family satisfaction.

Objectives of Managing Care

The advent of managed care has created new demands on the allocation of flexible funds. The challenge in Franklin County has been to capitalize on the benefits of managed care for high-risk, intersystem children, youth, and families without compromising the gains made in the area of flexible, nontraditional individualized service delivery. The following principle tenets of managed care were incorporated:

- Limited risk contracting (Lindstrom, 1994).
- Increased flexibility for the provider (provider level risk management capabilities).
- Increased clinical flexibility and responsibility for the provider.
- Simplified standardization of (a) funding mechanism for individualized plans, (b) tracking of individualized planning, and (c) accounts servicing capabilities.

Figure 1
Composition of Child and Family First Intersystem Council



- Improved outcome and family satisfaction tracking, and feedback
- Increased risk management capabilities for the funders

Project Description

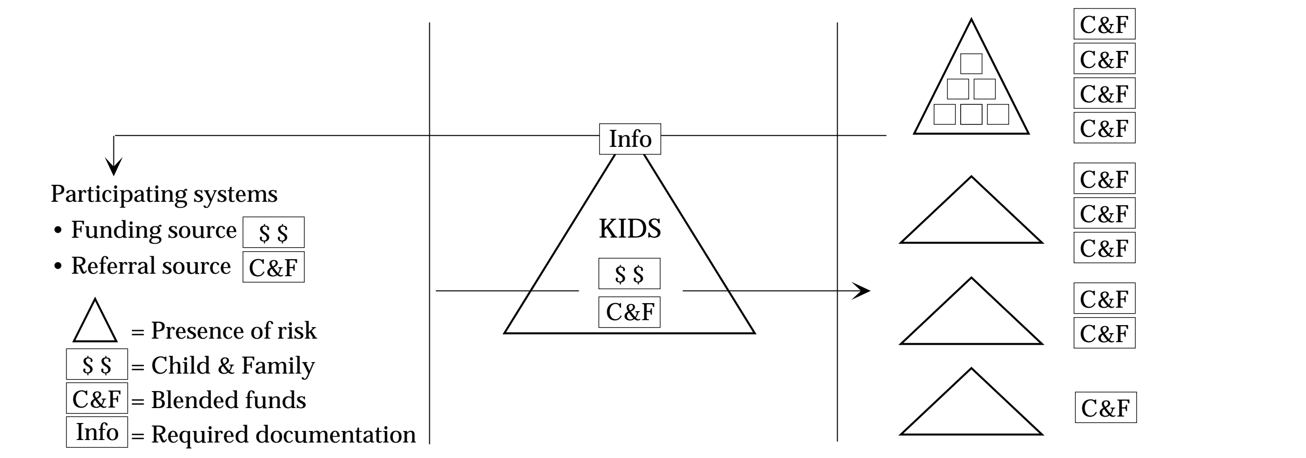
Structure of Contracting

The issues mentioned above create the value base on which the limited risk bundled contracting model employed in Franklin County is built. Contracting is done with individual providers and with a local Preferred Provider Organization (PPO). The contract itself coordinated funding agreements based on individual plans and budgets developed by the Child and Family team (CFT). After a plan and budget review process, the contract is written for the sum of the approved funding agreements with the particular agency or PPO (Figure 2 presents a flow of the contract process).

The contract allows the Lead Agency flexibility in using the grand total across individual plans. Hence the case manager has management capacity within the plan across line items (life domains), and the agency has larger risk management capacity across plans covered in the contract. In turn, the agency is responsible to provide (or contract for provision) and coordinate all services that are determined to be needed by the CFT. Since all planning and budgeting is a team centered activity, changes in services and expenditures are discussed in monthly team meetings and reported to the funder through meeting minutes, which are also published for all team members.

Upon the completion of the contract, which is renewed January 1 and July 1 of each year, the Lead Agency submits a Reconciliation which reports budget expenditures, actual receipt, and actual expenditures for each case and the contract as a whole. Payment is made in two quarterly installments over the course of a six month contract. The finalization of the funding agreements and the signing of the contract triggers the first payment in advance. This front loading is another strategy to support the providers ability to provide needed services without the concerns of cash flow, and to better manage their risk. The

Figure 2
Flow of Limited Risk Bundled Contract Model



second payment is triggered by the receipt of all required submissions for the first quarter.

Limited Risk Structure

The contract is designed to provide some incentive for cost savings without creating the impetus to avoid the delivery of needed services. Monitoring through required submissions and a conflict resolution procedure supply additional points of accountability. The contract details a profit/loss window. If actual expenses fall under the budgeted amount by up to a designated percentage, the agency, or PPO keeps that amount. All monies saved beyond the window are returned to the funder. Likewise, if actual expenses go above the budgeted amount, up to the designated percentage, the Lead Agency is responsible for continued services provision without additional dollars. All additional expenses above the window are negotiated for reimbursement.

Reporting and Monitoring

Fiscal information is provided mainly at the start and end of the contract period. Beyond this fiscal information, other reporting requirements are purposefully kept at a minimum in order to improve access to and the facilitation of services provided on the basis of flexible dollars. One required submission is team meeting minutes. The team is required to meet at least once every month to discuss progress, needed service, and budgetary changes. These changes, along with other pertinent information, are recorded in team meeting minutes in the interest of smooth communications and improved team functioning. These minutes are sent to KIDS as documentation of the team's ongoing planning and service provision, and changes in services and/or budgeting. The contract also requires submission of documentation of the tracking of seven behavioral indicators on a daily basis.

Family Satisfaction and Dispute Resolution

Another facet of monitoring contracted services is coordinated directly from the KIDS office. Family satisfaction surveys are conducted on a quarterly basis. The survey, developed through a series of parent focus groups, provides a direct link between funder and consumer. The contract indicates that the Lead Agency will be notified if family satisfaction levels fall below a certain point. This notification is intended as the completion of a necessary circle of communication connecting the funder, the provider, and the consumer. Such communication builds trust, which is the necessary element in any real quality improvement process. Complaints regarding service provision coming from participating systems are handled in similar non-threatening ways through procedures internal to KIDS, but developed in conjunction with the PPO. The major thrust is on communication links and trust. If the complaints persist, a more formal resolution conference may be held.

Conclusion

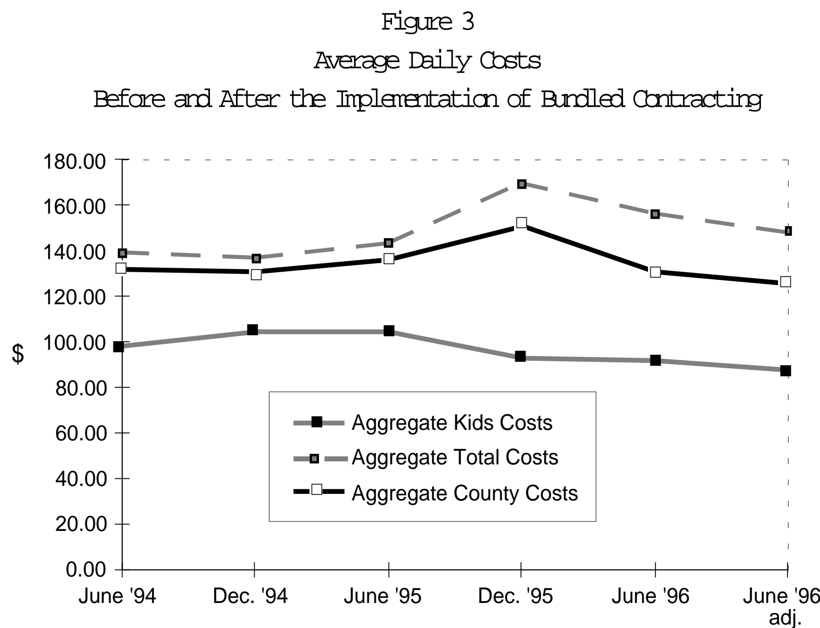
On a small scale, Franklin County has experimented with managed care principles based on individualized planning that is strength focused, needs driven, and family-centered. These experiments have led to a method of contracting that appears to maintain the integrity of individualized services, flexible funding, and financial accountability, while creating a foundation for managing services on a much larger scale. On this foundation, we can move in a variety of directions, such as a leveling or case rate system, as we develop the best structure of managed care for our community.

Financially, the purpose is to create a situation of shared risk. It is important that the providers

actually assume risk, as opposed to passing the cost of the risk on by inflating service and/or overhead costs. It appears that we have been successful in this area thus far. The overhead costs have been predetermined through a time study process and it is evident that providers have not offset the assumption of real risk by increasing service costs. Figure 3 outlines average daily costs before and after the implementation of bundled contracting. The increase observed at the time of bundles contracting can be attributed to a change in Medicaid billing rules in the State of Ohio. In the following period, the average daily costs return to previous levels. Patterns of inflation in services costs will be monitored in order to determine continuous success.

However, the success of this process of managing care through limited risk bundled contracting can not be judged solely on management and financial criteria. Innovations in managed care cannot be made at the expense of front line flexibility needed to serve children and their families with high level, multiple needs. The contracting mechanism described here has been in place for six months. Although it is too early to be conclusive, the initial impressions are favorable. With a multiple of changes occurring around (a) federal, state, and local funding strategies, (b) methods service provision, and (c) outcomes collection, it is impossible to single out particular effects of these contracts with extreme clarity. However, we have anticipated some impact from the implementation of this contracting. For example, we can look at behavioral indicators tracked during the service period. The indicators traced are alcohol and drug use, suicide attempts, AWOLs, assaultive behavior, self-injurious behavior, missed school, and arrests. During this contract period we have seen a slight increase in the number of days containing key behavioral indicators (see Figure 4). It is probable that the stress placed on outcomes in the contract will serve to increase the accracy of target behavior measurement.

Figure 3
Average Daily Costs
Before and After the Implementation of Bundled Contracting



We also anticipate that family satisfaction with planning and services will not be adversely effected. Further, it is hoped that this way of managing services will eventually serve to increase family satisfaction, and, conversely, that the need for outside conflict/dispute resolution will decrease.

Only through successful management of resources can we hope to make individualized service approach the norm, as opposed to the exception. We believe that this model of contracting provides a solid starting point.

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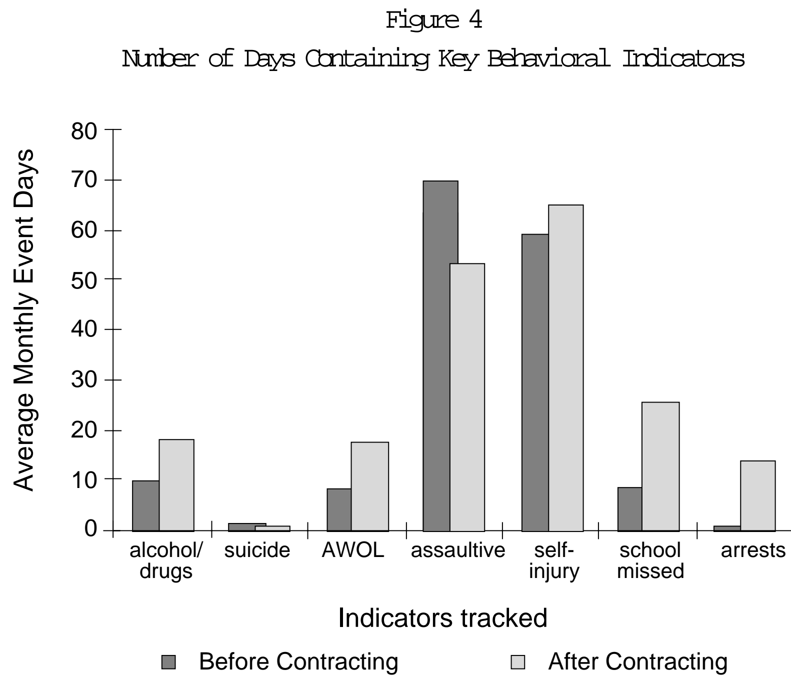
Figure 4
Number of Days Containing Key Behavioral Indicators



Managed Care Approaches to Children's Services within Public Systems of Care

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Introduction

Over the past three to five years, there has been a rapid transition to managed care models of health care financing and organization in the United States. This transition is now reaching the area of public mental health services. As states and governmental entities seek to control the increasing costs of Medicaid programs, many are moving towards implementation of managed care principles in the funding and delivery of mental health services. States are pursuing different models of managed mental health services under both the 1150 and 1915 Medicaid waivers, some contracting with established managed care providers and others attempting to convert components of their public systems into managed networks.

This transition, however, is not based on any solid data concerning the funding needed to serve populations traditionally served by the public mental health system, nor has it been based on any of the solid conceptual models and principles which have been tested with these populations. The managed care models which have been typically implemented by managed care contractors have not taken into account the special needs of Medicaid-covered populations. These special needs include children with severe emotional disturbances and other disabilities, economically distressed families, and members of under-served minority groups, as opposed to the majority middle class populations around which managed care services were initially developed.

This oversight has already led to adverse consequences in some state managed Medicaid contracts where the needs for services in these populations (and the consequent capitation) was grossly underestimated. On the other hand, many state mental health agencies are attempting to convert into managed care organizations and funding of services, but often without the infrastructure support for a successful conversion.

These summaries will address conceptual and infrastructure issues which both traditional managed care providers and converting state mental health systems must face to make an effective transition towards a managed care organization of services.

Clinical Experiences in Managed Care Implementation for Children with Serious Emotional Disturbances

Theodore Fallon, M.D., M.P.H.

The Robert Wood Johnson Foundation funded eight demonstration sites around the country with the goal of constructing arrays of service that might address the range of needs for the most disturbed children and youth and their families. The actual structures of these programs varied considerably and were each suited for the political, social, and clinical climate in which they were implemented. This project, the Mental Health Service Program for Youth, yielded eight examples of what is possible given adequate resources.

Clinical aspects of these programs were examined by observing the clinical work through case conferences by visiting clinicians. The success of these programs in working with these disturbed youth and their families seemed to be dependent on a number of attributes:

1. The services provided impact on all aspects of the youth and his family's life. At a clinical level, this translates into multiple system involvement including juvenile justice, child welfare, education, and mental health. On a systems level, this translates into pooled funding of these agencies, in essence, pooling an array of resources and flexibly determining their most efficacious use.

   An example of this was seen at one site when a physically large adolescent repeatedly threatened the residential staff. During these times, the juvenile justice system allowed use of the detention center for time out periods. The youth was able to settle down enough to use residential support and educational services, and eventually the youth became a good student.

2. This example also illustrates the utility of coordinated services.

3. Services also need to be attractive. Many examples were seen in which youths and families had repeatedly rejected services, but when the services offered something desirable, families used them and in that setting were able to develop alliances with workers.

4. The services that were the most successful involved considerable creativity in the service of being responsive to the youth and family. This means that the clinicians had control of the services and access to experts if they themselves were not expert. This expertise involved two components: (a) knowledge and practical skills in engaging and holding on to the families and children (characterized by focusing on the child and families' strengths, building rapport and self esteem); and (b) knowledge and practical skills in assessing and working with deficits including psychopathology (necessary in order

to know how to direct the rehabilitative services that were needed to move the child and family toward normal development).

5. The services needed to have sufficient resources to be able to sustain them for as long as was necessary. This required a commitment on the part of the organizations involved (i.e., an ability to withstand the political changes as well as the personnel changes). This attribute seemed to be the most difficult to attain, especially in the environment of managed competition where competition implies competition of services where one naturally displaces another.

These five attributes were present to some degree in all of the systems of care that were able to make gains in working with children and youth with serious emotional disturbances.

Best Principles for Managed Care Request for Proposals

Andres J Pumariega, M.D.

Children and adolescents covered by Medicaid often have multiple developmental needs and complex problems. Effective intervention thus needs to include a full array of services in a community-based system of care, based on Child and Adolescent Service System Program (CASSP) principles. The American Academy of Child and Adolescent Psychiatry's Task Force on Community Systems of Care, in collaboration with other mental health professional and service associations and organizations, has developed a document titled *Best Principles for Managed Medicaid Request for Proposals.*

The *Best Principles for Managed Medicaid Request for Proposals* is designed to assist state decision makers in selecting managed care Medicaid vendors or developing public managed systems that can most effectively serve the population of Medicaid covered child population, particularly multi-problem children with severe emotional disturbances. It defines principles that should be inherent in high quality programs. It addresses such issues as governance of service systems, design of benefits, access to services, development of treatment plans, triage and assessment, treatment services, case management, quality assurance, information management, and provider support by states.

Providing a full continuum of services allows the care providers to customize the care plan to most effectively help the patient and family. The focus of such a model is on managing services rather than managing benefits a priori, which is discriminatory and restrictive with under-served populations. This model also ensures coordinated care and the establishment of communication and collaboration across disciplines and agencies for effective coordination of services. Care plans must be patient and family centered, with their full involvement in the assessment and treatment processes. These programs also need to develop programs and monitor outcomes in the following areas: (a) access, (b) functional and clinical outcomes, (c) prevention, (d) wellness, (e) community acceptance/responsiveness, and (f) patient/family satisfaction.

This document has been forwarded to all 50 Medicaid directors, and has received overwhelming positive responses, including responses from over 40 states requesting more information and consultation. Information regarding the principles covered in this document, as well as the approaches being considered to evaluate its adoption and implementation can be obtained from the author.

Symposium: The Impact of Managed Care on the Utilization of Child and Adolescent Mental Health Services: Recidivists in an Emergency Screening Team Site

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Introduction

This collection of summaries presents the latest analyses of data addressing the role of system changes in decision-making and service utilization in child and adolescent (C/A) mental health emergencies. In Massachusetts, private management of mental health and substance abuse benefits in the public sector began in 1992. Since then, increased management of these benefits has occurred in the private sector as well. The findings reported in this symposium are part of on-going efforts to evaluate private sector strategies to manage public sector mental health benefits.

In previous analyses (Young, Simon, Nicholson, & Bateman, 1996), the Child and Adolescent Service System Program (CASSP) concepts of least restrictive environment, community-based services, and individual need provided a framework for exploring the contributions of demographic, clinical, and fiscal variables to dispositions in emergency mental health screening of children and adolescents, before and after the private management of Medicaid benefits. As expected, the volume of screening episodes increased after managed care was implemented. There was, however, a significant decline in the proportion of dispositions to inpatient hospital settings, suggesting that children's needs were being met in less restrictive settings after the implementation of the managed care program.

During the same time period, there was a significant increase in the number of dispositions to community-based crisis stabilization programs, indicating that many children who would have been hospitalized were being diverted to community-based programs after the implementation of the Medicaid managed care program. Those emergency episodes in which children and adolescents were in greatest clinical need, however, continued to result in hospitalizations after the implementation of managed care, suggesting that children's individual needs were factored into decision-making.

In this symposium, we present three analyses of data from C/A recidivists at a mental health emergency screening site in pre- and post-managed care time periods, defined by the implementation date for Medicaid managed care. These analyses were conducted to address the fears of many clinicians that, in a managed care environment, clients are provided brief, "band-aid" services that do not fully address underlying problems. The assumption made by many clinicians is that utilization reviewers are reluctant to approve more costly services that clients may really need, or that they will not approve them until less costly services have been tried. The common concern is that clients will have to keep coming back for treatment until their needs are adequately met.

The following questions were addressed regarding the impact of managed care on recidivists at an emergency screening site:

- Was there a change in the number of recidivists and, specifically, in the number of Medicaid recidivists following the implementation of managed care?
- Which clinical, client, and fiscal variables predicted becoming an Emergency Mental Health Services (EMHS) recidivist in the pre- and post-managed care periods?
- What were the disposition patterns for recidivists in the pre- and post-managed care periods?

Method

Data for all three analyses were drawn from the daily log sheets of the EMHS program at the University of Massachusetts Medical Center in Worcester, MA. These logs contain: (a) demographic and clinical characteristics for clients receiving services, (b) type of insurance, (c) referral source, and (d) disposition.

We looked at clinical and fiscal variables and dispositions for children and adolescents over a 2-1/2 year period from October, 1991 to March, 1994. We divided the 2-1/2 year period into 3 parts: (a) *pre-managed care* (i.e., one year prior to the implementation of managed Medicaid mental health benefits on October 1, 1992); (b) a six month transition period; and (c) *post-managed care* (i.e., the year following the start-up of the managed Medicaid program). We did not include the transition period in our analyses to avoid drawing conclusions based on the normal fluctuations that are involved in any major systems shift.

Although Medicaid recipients account for the majority of EMHS episodes across the 2-1/2 year period, EMHS also became the screening site for a number of private managed care organizations during this time. Therefore, the research period really represents a time of overall systems change. For this reason, both Medicaid and non-Medicaid recidivists were included in our analyses, unless otherwise noted.

Impact of Managed Care on the Clinical Profiles of Recidivists

Lorna Simon, M.A. and Stephen Dine-Young, M.A.

In this summary, demographic, clinical, and insurance profiles of C/A recidivists in the pre- and post-managed care periods were compared using chi-square tests. Again, clients screened in the transition period were excluded.

There were a total of 482 children and adolescents seen in the pre-managed care (10/1/91 to 9/31/92) and post-managed care (4/1/93 to 3/30/94) periods. Of these clients, 101 were recidivists. The clinical and payor characteristics of the recidivists are presented in Table 1. The gender split was relatively even. A majority of recidivists were adolescents, and most either lived with family or at a residential treatment facility. The difficulties that recidivists were most likely to present with were *harmful to self or other* and *problem behaviors* (i.e., “acting out”); these difficulties corresponded to frequent diagnoses of disruptive D/O, Post Traumatic Stress Disorder (PTSD)/Anxiety D/O, and Adjustment D/O. Over two-thirds of the recidivists had Medicaid insurance, while most of the remaining clients had some form of private insurance (either indemnity or HMO).

Of the 101 C/A recidivists, 37 (17% of the total C/A clients) were screened in the pre-managed care period, and 64 (24% of the total C/A clients) were screened in the post-managed care period–an increase that was statistically significant ($\chi^2 = 4.01$, $p < .05$).

Although none of the clinical or demographic variables were significant across the two time periods, there was a statistically significant increase in the proportion of recidivists who were Medicaid beneficiaries in the post-managed care period (75% versus 54% in the pre-managed care period; $\chi^2 = 4.65$, $p < .05$).

Table 1
Characteristics of Children/Adolescents Readmitted to EMHS: Pre- and Post-Managed Care

Variable	Percentage
Gender	(n = 101)
Male	53.5
Female	46.5
Age	
< 8	5.0
9-11	7.9
12-14	34.7
15-17	54.5
Living Situation	
Self/Family	51.5
Residential	33.0
"Other” (e.g., juvenile detention)	15.5
Presenting Problem	
Harmful Behavior (to self or other)	49.5
Problem Behavior ("acting out")	42.6
Psychotic	5.0
"Other” (e.g., substance abuse)	3.0
Diagnosis	
Disruptive D/O	42.6
PTSD/Anx	21.8
Adjustment D/O	14.9
Psychotic D/O	7.9
Mood D/O	6.9
"Other” (e.g., substance abuse)	5.9
Insurance	
Medicaid	67.3
Non-Medicaid (priv indemnity or HMO)	27.7
No Insurance	5.0

There was an increase in the number of emergency room recidivists after the implementation of managed care. This difference can be attributed to the management of benefits through support by the additional finding that there were no differences in clinical characteristics in the pre- and post-managed care periods, suggesting that there was little change in the client population across the two time periods. The finding that a larger proportion of the recidivists were Medicaid clients in the post-managed care period can probably be attributed to new regulations requiring that all Medicaid clients be screened at EMHS before receiving other services.

Factors Contributing to a Child or Adolescent Becoming a Recidivist at an Emergency Mental Health Screening Site Pre- and Post-Managed Care

Stephen Dine-Young, M.A. and Lorna Simon, M.A.

In the second summary, demographic, clinical, and insurance variables were tested as predictors of C/A clients becoming recidivists before and after the implementation of managed care.

Method

Logistic regressions for the pre- and post-managed care time periods were conducted to predict the odds of becoming a recidivist, as determined by more than one visit to EMHS during the time period. For each of the periods, the following predictors were considered: age, gender, diagnosis, and insurance. Adjusted odds ratios were calculated for each predictor.

Results

The results of the logistic regression for the pre-managed care period are presented in Table 2. Only a diagnosis of adjustment disorder significantly predicted whether a C/A client became a recidivist in the pre-managed care period, and the relationship was negative (ß = -1.69; $p < .01$). A child diagnosed with this a disorder was less than one-fifth as likely to be an EMHS recidivist than a child diagnosed with disruptive D/O.

The results of the post-managed care logistical regression are presented in Table 3. Again, only the coefficient for adjustment disorder was significant and the relationship was negative (ß = -1.04; $p < .05$). In addition, being a Medicaid client also signifi-

Table 2
Factors Predicting Odds of Child/Adolescent Readmission to EMHS:
Pre-Managed Care

Variable	Coefficient	Wald Statistic	Odds Ratio
Age			
Age < 11	-0.70	-0.99	0.50
Age 12-14	-0.09	-0.22	0.91
Age 15-17 (reference)			
Gender			
Female	-0.26	-0.66	0.77
Male (reference)			
Diagnosis			
Mood D/O	-1.87	-1.76	0.15
Anxiety D/O	0.98	1.69	2.66
Adjustment D/O *	-1.69	-2.87	0.18
Other Diagnosis	-0.67	-1.10	0.51
Disruptive D/O (reference)			
Insurance			
No Payor	-0.43	-0.59	0.65
Medicaid	-0.20	-0.48	0.82
Private (reference)			

* $p < .05$

cantly predicted whether a C/A client would become a recidivist (ß = 1.42; p <.001). Medicaid clients were more than 4 times as likely to return to EMHS than non-Medicaid clients.

It also should be noted that in the pre-managed care period there was a trend toward significance for mood disorders (ß = 1.87; $p < .1$) and PTSD/ Anxiety disorders (ß = .98; $p < .1$). These trends were not evident in the post-managed care period.

Table 3
Factors Predicting Odds of Child/Adolescent Readmission to EMHS: Post-Managed Care

Variable	Coefficient	Wald Statistic	Odds Ratio
Age			
Age<11	-0.76	-1.61	0.47
Age 12-14	0.22	-0.63	1.25
Age 15-17 (reference)			
Gender			
Female	-0.37	1.13	0.69
Male (reference)			
Diagnosis			
Mood D/O	-0.24	-0.43	0.79
Anxiety D/O	0.40	-0.92	1.49
Adjustment D/O *	-1.04	2.42	0.35
Other Diag.	0.23	0.43	1.26
Disruptive D/O (reference)			
Insurance			
No Payor	0.00	0.00	1.00
Medicaid*	1.42	3.95	4.15
Private (reference)			

* $p < .05$

Conclusions

The finding that adjustment disorder negatively predicted a C/A EMHS client becoming a recidivist in both the pre- and the post-managed care periods is understandable in that it is the least severe of any of the diagnostic categories; clients assigned adjustment disorder diagnoses are probably less likely to need repeated care. Given the post-managed care period requirement that Medicaid recipients be screened at EMHS, the finding that having Medicaid insurance significantly predicted a C/A client becoming a recidivist also is not surprising.

Clinicians may be concerned about the trend toward significance with the diagnoses of mood disorder and PTSD/anxiety disorder in the pre-managed care period that did not exist in the post period. While these findings are not strong enough to draw clear interpretations, there is some indication that clinical factors are being given less consideration in the post-managed care period. Further investigation is necessary.

The Question of Patterns of Dispositions

Joanne Nicholson, Ph.D. and Joseph R. Mara, B.A.

In this summary, levels of restrictiveness of dispositions for C/A mental health emergency screening recidivists in the pre- and post-managed care period were considered. In previous analyses (Young et al., 1996), it was found that although emergency screening volume increased significantly in the post-managed care period, admissions to inpatient settings significantly decreased. In addition, this decrease seemed to be in direct proportion to the volume of episodes resulting in referrals to newly developed crisis stabilization programs (e.g., community-based care). It was assumed that an increase in referrals to community-based services was a good thing.

There are questions, however, that may nag certain stakeholders (i.e., both providers and consumers). Does this increase in referrals to community-based services reflect a lack of access to the appropriate level of care for those children and adolescents in greatest clinical need? Also, do children keep coming back until their needs are ultimately addressed via the inpatient level of care they really needed in the first place? If this is the case, costs, both dollar and clinical, may only be delayed and higher as an end result.

Method

We developed a very simple coding scheme for describing the pattern of dispositions for C/A mental health screening recidivists. We examined the dispositions for recidivists over time, and if the level of restrictiveness of the dispositions remained the same, a code of "no change" or "=" was assigned. If the level of restrictiveness of the dispositions decreased over time, this was coded as "decrease" or "-." If the level of restrictiveness of the dispositions increased over time, this was coded as "increase" or "+."

There is a weakness in this strategy; change over time was condensed into one code. In doing this, important information was lost that may have contributed to changes in dispositions over multiple emergency screening episodes (e.g., changes in age of the child or adolescent and related changes in available service options and the developing course of a disturbance or disability).

Chi-square tests were used to determine if there were significant differences between pre- and post-managed care periods in patterns of dispositions.

Results

None of our independent variables (i.e., clinical and payor characteristics) were related to change in level of restrictiveness of dispositions in the pre- or post-managed care periods, either for the total group of recidivists or the Medicaid subscribers who were recidivists. It would seem that the implementation of managed care had no impact on the pattern of restrictiveness of dispositions for this sample, as far as our simple coding scheme could detect.

Discussion

One way to think about this finding is that children are continuing to receive the care they need. There may be something about their ages or stages of illness that is more powerful than the payor variable in determining disposition.

There was no increase in numbers of children and adolescents in the *increasing level of restrictiveness* group, which would have suggested that children were being kept from the level of care they required until the gatekeepers, despite their efforts to contain costs, could no longer deny them access. Rather, we still see the same proportions of children for whom alternative plans are tried before they are hospitalized. And, even if they are eventually hospitalized, there may be some clinical benefit to trying alternatives first.

What is clear is the need for coordinated evaluation efforts among public and private sector agencies and providers if we are to truly understand the impact of managed care on such important issues as decision-making, service access and quality of care.

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A Community-Based Continuum of Services Compatible within the Managed Care Environment

Community-based Treatment Hubs

The Spurwink School offers a series of treatment "Hubs" that are positioned in a tri-state area. This summary outlines the "Hub" model and its key features.

Administrative Structure

The continuum of services within the Spurwink system involves community based programming in a wide geographic area in the states of Maine, New Hampshire, and Rhode Island. This involves a central administrative structure as well as decentralized program supervision structures. The central administration is involved in such activities as financial administration and accountability, program coordination, training, governance, computerized systems, human resources coordination, clinical and educational oversight, quality assurance, licensing, accreditation, government relations and fundraising. The decentralized supervision is based on the use of program directors who provide oversight to clusters of programs which are based upon the categories of services and clients, the geographic location or the setting in which services are provided.

Within the children and adolescent segment of the program, the geographically specific day treatment centers serve as "Hubs" for the day and residential programming; each has a program director. Program directors also serve an integral function at the adult

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developmental disabilities day activity and residential programs, the Spurwink Clinic and the two residential treatment centers, including the specialized adolescent and the long-term staff secure programs. These program directors are the vehicle for communication, quality assurance, training, financial accountability, treatment, education, and various other activities. This entire model involving a central administrative structure and a decentralized program supervision structure managed by a program director assures integration of services and accountability.

The Generalist Model

The core of the treatment activities is via the professional identified as "Generalists." The generalist became the core of the treatment paradigm employed at Spurwink; and thirty-five years later, across three states and more than 60 sites, it remains the philosophical approach; and importantly, the key to its managed care activities.

This generalist model was developed from the recognition that child care workers and teachers are the core professionals most exposed to the challenging behavior of kids with emotioonal or behavioral disturbances.

In order for these front-line workers to be effective, immediate, and responsive, support services and supervision are required. This is the role of the generalist - the one who integrates and coordinates all that goes on in the life of a particular child. The generalist is responsible for working with the child's family, working with the clinical staff, working with child care workers, and working with teachers. The task is to communicate, integrate, translate, support, and supervise.

The generalist model recognizes the fact that fragmented children and families cannot effectively be treated with fractionalized services.

The fascinating reality of this model has been its adaptability. Established as a key component of residential treatment, the generalist has been used effectively in day treatment, adult intermediate care facilities and community based residences designed to bring youngsters out of intensive in-patient facilities.

With this as its philosophical core, it is easy to see why Spurwink began to expand its mission in a decentralized fashion. Each community that was developed was designated as a "Hub." For every hub there is a series of residential alternatives, a day treatment site, a cooperative relationship with a public school and a network of consultants and providers, ranging from psychiatry to nutritionists to vocational training specialists. Each community "Hub" and all of its components are linked together and held accountable by the Generalist, the treatment "Hub."

Given the least restrictive to most restrictive, definition of the residential continuum, Spurwink was able to respond quickly to being able to accept difficult to place and difficult to manage youngsters. This also permitted intra-agency movement of youngsters, if necessary. Because of this Spurwink developed the reputation of being flexible and adaptive. Of course, this is a core requirement within the managed care paradigm.